



U.S. Department
of Transportation
**Federal Aviation
Administration**

INFORMATION FOR APPLICANT

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
TO THE FEDERAL AVIATION ADMINISTRATION (FAA)**

Privacy Act Statement

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Information requested on this form is solicited under the authority of Title 49 of the United States Code (Transportation) Sections 109(9), 40113(a), 44701 - 44703, and 4709 (1994), formerly codified in the Federal Aviation Act of 1958, as amended, and Title 14 of the Code of Federal Regulations (CFR), Part 67, Medical Standards and Certification, and Title 5 U.S.C. 33301.

Submission of this information is mandatory and incomplete submission will result in delay of consideration or denial of application for an airman medical certificate or the medical clearance of a Federal Aviation Administration (FAA) employee.

The purpose of information is to determine whether an applicant meets FAA medical requirements to hold an airman medical certificate or for further consideration under 14 CFR 11.53 and 67.401 or for an FAA employee medical clearance.

It is also used to depict airman population patterns and to update certification procedures and medical standards.

The information collected on this form becomes a part of the Privacy Act System of Records DOT/FAA 847, General Air Transportation Records on Individuals, and is provided the protection outlined in the system's description as published in the *Federal Register*.

Tear off this cover sheet before submitting this form.



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TO WHOM IT MAY CONCERN, **PLEASE PRINT:** _____

I, _____ / _____ / _____
(FIRST) (MIDDLE) (LAST)

born on _____ / _____ / _____, at _____
(Month) (Day) (Year) (City)

_____ / _____ presently residing at _____
(State or Country) (Current residence)

_____ / _____ / _____ / _____
address) (City) (State) (Zip Code)

hereby authorize any physician or other person who has attended, examined, or treated me, or any, clinic, hospital, institution, company, or Federal, State, or municipal agency, office, or bureau which may have information concerning my medical history, to release to the Administrator of the FAA, or the Administrator's medical representative, any available information or records concerning my medical history in their knowledge or possession.

This authorization is given pursuant to Title 14 of the Code of Federal Regulations (CFR) 67.413, which relates to the acquisition of medical information for airman medical certification (14 CFR Part 67). Alternatively, this authorization is given pursuant to Title 5 U.S.C. 33301 which relates to FAA employee or employee applicant positions covered by medical standards found in Appendix 1 of FAA Order 3930.3A, Air Traffic Control Specialist Health Program. This information is necessary to determine whether I meet the applicable medical standards for an airman medical certificate or, alternatively, FAA medical clearance I hold or for which I have made application.

I have also been known by the following name(s): _____
_____ (If none, state "None").

A reproduction of this authorization shall be deemed as effective and valid as the original.

(Signature) _____ (Date) _____

SEND INFORMATION TO:

☐ Aeromedical Certification Division, AAM-300
FAA, Civil Aeromedical Institute
Mike Monroney Aeronautical Center
P.O. Box 26080
Oklahoma City, OK 73126-0080

☐ Other Addressee: _____

FURNISH SIGNED AND DATED COPY TO PHYSICIAN OR HOSPITAL WHEN REQUESTING COPIES OF RECORDS BE SENT TO THE ABOVE CHECK BOX. ANY EXPENSE INVOLVED IN PROVIDING THESE RECORDS IS THE RESPONSIBILITY OF THE APPLICANT -- NOT THE FAA.